THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION
PUBLISHED MONTHLY

Volume VI St. Augustine and Jacksonville, Florida, September, 1919 Number 3

ORIGINAL ARTICLES

STRICTURE OF THE URETER, WITH REPORT OF TWO INTERESTING CASES.*

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Chronic stricture of the ureter is a disease of far greater frequency than is commonly supposed, and each year sees many sacrifices of innocent appendices, tubes and ovaries as a result of our too hastily attributing pains in the lower quadrant of the abdomen to disease of these organs.

Dr. Guy L. Hunter, of Baltimore, Md., in a series of papers in recent years has done much to bring this subject to the attention of the medical profession, but it needs still more emphasizing in order that it may receive due consideration as a member of our list of probable causes for a number of unrelieved appendectomized patients. This failure to consider chronic ureteritis with stricture as a rather frequent disease, along with the wide variety of symptoms which frequently give voice to its presence, is undoubtedly responsible for the small number of correct diagnoses of the condition.

The pathology of stricture of the ureter from chronic ureteritis is the same as that of stricture of any other hollow tube. There is a localized infection, round cell infiltration, perhaps ulceration, fibrous tissue hyperplasia, scar formation and contraction of the scar. The chronic inflammatory strictures probably usually follow localized infection, hematogenous in origin, being metastatic from some focal infection elsewhere in the body—tonsils, teeth, sinuses, etc. It is probably at times the result of contiguous infection in the cervix and broad ligament of the female, the seminal vesicles of the male, and the appendix of both sexes.

Rosenau's remarkable work on the selective activity of various strains of the streptococcus in explanation of metastatic infections of the various serous membranes, the duodenum, etc., opens up a wonderfully fruitful path of research for the future in the explanation of obscure etiology for centralized local infections, and will possibly explain a good many of the cases of ureteritis with stricture.

The symptoms of stricture of the ureter vary very materially according to the stage of the disease and the secondary complications, inasmuch as a great many cases of ureteral and renal calculus, hydronephrosis, pyonephrosis, etc., have their inception in stricture of the ureter.

A summary only of the symptoms due to this condition can be given in a paper of this length. They are:

1. Those referable to the urinary tract.

(a) Pain in the region of the bladder, the affected ureter and the kidney, which may vary from an occasional dull ache to the most violent type of colicky pain.

(b) Frequency and urgency of urination. I have known patients to become almost physical wrecks on account of loss of sleep from a constant overpowering desire to urinate.

(c) The urine may show blood, pus-cells or bacteria or may be entirely normal. Normal urine does not necessarily rule out the affection.

2. Reflex or referred symptoms. These cover almost every point in the anatomy but the most frequent are:

*Read by title before the Forty-sixth Annual Meeting of The Florida Medical Association, at Miami, May 20-22, 1919.

(a) Pains in the hip of the affected side, in the region of the sacroiliac joint, down the back of the thigh and in the calf.

(b) Gastrointestinal reflex phenomena such as gaseous eructations, nausea, gaseous distention of the intestines, heartburn, etc.

Diagnosis: The diagnosis is made by careful history-taking and physical examination plus cystoscopy alone or in conjunction with the X-ray.

(a) A careful history will frequently direct one's attention to the ureter as the offending organ. A careful physical examination will usually be of more negative than positive value in ruling out the conditions with which it might be confused, because aside from abdominal, vaginal or rectal tenderness over the area of ureteral infection, there are practically no positive physical signs of the lesion.

(b) Cystoscopy with catheterization of the ureters is the surest way to arrive at a positive and accurate diagnosis. Just as it is necessary to use an olive-tipped bougie in definitely locating and determining the diameter and length of strictures of the urethra, so is it necessary to use a similar instrument in locating and determining the character of strictures of the ureter. This is supplied to us in the ureteral catheter with a spindle-shaped wax bulb near the tip, which may be moulded to any desired size.

The X-ray is a very valuable adjunct in determining the presence or absence of stones behind the stricture, and in certain cases in determining the size and shape of the dilated kidney pelvis by the use of a pyelogram, but it is not essential in making a diagnosis of stricture.

The treatment in abstract is as follows: For the early cases dilatation of the stricture through the cystoscope, and, if there is a secondary pyelitis, lavage of the kidney pelvis. Late cases, treatment of the complications — calculi, pyonephrosis, destructive hydronephrosis, etc.—by surgical means.

The following two cases are delineated as examples of late complications of stricture with definite clear-cut histories of onset (when taken with stricture in mind). Both cases came under my observation while I was chief of the surgical service at the Naval Base Hospital in Charleston:

CASE 1.—Corporal A., U. S. Marine Corps. Entered hospital December, 1917, complaining of pain in the right upper quadrant of the abdomen, of a constant and rather severe type. Temperature 101, pulse 100 on admission.

Physical examination showed a patient evidently in a good deal of pain, right leg flexed on the abdomen, marked rigidity of the right rectus muscle, tenderness over the region of the gallbladder and extending around the loin to the costovertebral angle. No mass could be felt on palpation. The skin and conjunctivæ were markedly jaundiced. The remainder of the physical examination was negative.

Blood examination showed a white cell count of 13,000 with 80 per cent of polymorphonuclears.

Urine examination: Very turbid; bile stained; slightly acid; specific gravity 1025; albumin, marked trace; sugar negative.

Microscopic: Showed the specimen loaded with pus-cells; no casts, no red-blood cells.

As is the custom in the Navy, this patient brought his health record with him, which showed that he had been transferred to us with a diagnosis of gallstones, which indeed at first glance appeared to be a correct diagnosis. He had been on the sick list four times during the past two years with the same diagnosis each time. The urine being loaded with pus, however, and the extreme tenderness in the costovertebral angle in addition to that in the gallbladder region, led us to go more closely into the case. The early history as told by the patient was as follows: He had had an acute attack of tonsilitis early in 1916, which kept him in bed for a week. Two weeks later he began having pain in the right side of the abdomen, radiating to the kidney region and into the bladder, with frequency of urination and the passage of blood-tinged

urine. This lasted for a month and disappeared. Three months later he began having recurrent attacks of dull aching pain in the right kidney region, which became gradually more severe until the first time he was placed on the sick list early in 1917. At this time he had an acute attack of pain in the same region and also in the right upper abdomen with chills, fever, jaundice and extreme tenderness over the right abdomen. It was at this time that the first diagnosis of gallstones was made. He had had three subsequent similar attacks, each lasting one to two weeks and each time the diagnosis of gallstones was made.

He was placed upon palliative treatment, including icebags, forced liquids and rest in bed, and in one week the attack had subsided. At this time a combined cystoscopic and X-ray examination was made with the following findings: Bladder, both meati, left ureter and left kidney normal. Right ureter showed a stricture 8 cm. above the bladder with infected urine from the kidney above. Functional test showed 5 per cent phenolsulphonephthalein in one hour from the diseased kidney. A pyelogram with thorium nitrate showed the pelvis of the kidney very markedly dilated and the calices blunted, so that there was a mere shell of kidney tissue remaining. For several days following the examination the patient showed a return of his jaundice, which gave us the clue to the cause of the jaundice during the attacks; the explanation being that the dilated kidney pelvis displaced the second portion of the duodenum forward and inward, causing an interference with the flow of bile through the common duct.

A nephrectomy was done a week later and this explanation was strengthened by the finding of adhesions between the thickened inflammatory pelvis and the duodenum. The patient made an uneventful recovery from the operation and a year later had gained twenty-five pounds in weight and had had no further trouble.

The sequence of events in this case was most likely as follows: Tonsilitis, metastic ureteritis, scar formation and stricture in the ureter, dilatation of kidney pelvis, infection of stagnant urine with the conversion of a hydronephrosis into a pyonephrosis.

Case 2. Chief Petty Officer S. Arrived at the Naval Hospital in August, 1918, from Guantanamo, Cuba, having been transferred North for his health's sake. He was entered with the diagnosis of pancreatic cyst, under which diagnosis he had been carried on the sick list in Cuba since August, 1917. He entered with a discharging sinus in the upper right abdomen as his only complaint, otherwise in good health.

His health record showed that he had been operated upon in the summer of 1917, the diagnosis at the time being pancreatic cyst. Operative notes as recorded in the health record showed that an upper right rectus incision had exposed a large cystic mass filling the upper right quadrant of the abdomen, which was filled with straw-colored fluid. The diagnosis of pancreatic cyst was confirmed, the cyst wall sewed to the parietal peritoneum, the cyst opened, drained and the cavity packed with gauze. Since that time the sinus which followed the operation had been cauterized several times, but showed no disposition to close and continued to saturate several dressings a day until he was finally transferred to us.

The junior medical officer in making the routine examination of the case detected a urinous odor to the discharge and so informed me when he was brought to me during the surgical consultation hour. Physical examination revealed a healthy man of thirty years of age with a smooth round sinus, 1 cm. in diameter, in the upper right quadrant of the abdomen, discharging a large amount of straw-colored fluid with a distinctly urinous odor; examination was otherwise negative. Phenolsulphonephthalein, ½ cc., given intravenously, was detected in the secretion from the sinus in twenty-five minutes, con-

firming our suspicion that the sinus led to the kidney. Cystoscopic examination: This showed normal bladder, left meatus, ureter and kidney. The right meatus showed no spurts of urine, though an occasional ineffectual peristaltic movement was seen. I was unable to get a ureteral catheter past a stricture in the lower inch of the ureter at this time. Subsequently, however, I succeeded in passing it, and the catheter appeared through the abdominal sinus. It was partly withdrawn, the sinus plugged, thorium nitrate injected through the catheter and an X-ray plate taken. This showed a clear-cut outline of the kidney pelvis slightly enlarged and attached to the anterior abdominal wall. Thus the "pancreatic cyst" was in reality a large hydronephrotic sac and the kidney pelvis, instead of a cyst wall, had been sewed to the anterior abdominal wall.

Careful inquiry into the past history of this case showed it to be almost identical with the other case. Tonsilitis followed by symptoms of right ureteritis and later stricture and the development of a hydronephrotic kidney.

An attempt was made to reestablish drainage down through the ureter by a catheter inserted through the cystoscope to the fistula, heavy linen thread pulled back through the ureter and to it tied a small rubber catheter. I wished to save what was evidently a kidney with good function, if possible. This scheme met with failure, however, and I was forced to advise either the wearing of a urinal fitted to the fistula or a nephrectomy. The patient decided to try a urinal, for a few months anyway, and was wearing it when I left the service.

These cases of chronic stricture respond kindly to treatment through the cystoscope, if diagnosed before the onset of destructive lesions of the kidney, and the treatment is frequently the means of saving them useless and even dangerous operations. I have five cases of early stricture of the ureter under treatment at the present time, all responding nicely to dilatation and pelvic lavage.

ANOREXIA NERVOSA COMPLICATED BY VOMITING AND PAIN; A NEW POINT IN DIAGNOSIS AND A NEW METHOD OF TREATMENT.*

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While it is the purpose of this paper to enter directly into a consideration of the diagnosis and treatment of this perplexing condition, it will hardly be out of order to spend a few moments on the general definition.

The term anorexia implies a state where the sensation of hunger is completely absent, combined with a total loss of appetite. It is often associated with both functional and organic stomach conditions. Anorexia nervosa may be seen as a primary affection arising from hyperesthesia of the gastric mucus membrane or by depression of the hunger center.

Symptomatology of Anorexia Nervosa.

The patient complains of loss of appetite and eats less day by day. He eventually rejects all solid food and no matter how toothsome or beautiful or how daintily his tray may be prepared or how urgently he may be pursuaded to partake of it, he rejects all but a small amount of liquids which he imbibes most reluctantly. He obstinately refuses to eat until he becomes emaciated and pale. He lies limp and weak in a semi-comatose state. His extremities are clammy and temperature subnormal.

The ætiological factors which usually precede this state are extreme mental depression, such as worry, anxiety, disappointment, the death of a member of the family, fright, etc.

The diagnosis can usually be made with fair accuracy after a carefully taken history, physical examination and analysis of blood, stomach contents, urine, etc.

When the physician is called upon to treat one of these cases presenting the picture out-

*Read before the Duval County Medical Society, May, 1919.

lined above, he stands face to face with a task that would tax the skill and ingenuity and the patience of any man that practices the healing art.

The treatment of such complications as vomiting and epigastric pain coupled with a steadily lessening desire for food, to which I invite your attention, presents a most stupendous undertaking.

The new point in diagnosis to which I have referred is, that the microscopic study of the mucus taken from the stomach of these patients usually shows many incorporated epithelial cells if the condition is purely a nervous affection, whereas there absence suggests an organic state.

My records up to the present time do not cover a sufficiently large number of individual cases to render this point a classical sign in the diagnosis, although my findings in a considerable number of instances have been rather constant and helpful in separating neurotic cases from those of organic origin.

The accustomed method of treatment of the aggravated cases consists briefly of rest in bed; administration of the bitter tonics; intragastric farradism; rest cure in sanitarium, and forced feeding by introducing a short tube one-half the length of the gullet; rectal feeding; mustard plaster on the epigastrium for counterirritation, etc.

My plan is to select a well-ventilated, quiet room up stairs, if possible, leading out upon an open porch. Remove all unnecessary wall decorations, drapery, bottles, flowers, etc. Give the stomach twenty-four hours' rest from all kinds of food and medication, directing the nurse to administer one tablespoonful of very hot distilled water to the patient every hour during the day or until pain and nausea seem to be diminished. Require all food kept out of sight and caution the nurse not to even use the words "pain," "food," "medicine," "nausea" or "vomiting" at any time in the presence of the patient.

These details may appear irrelative and unnecessary, but when we recall that people frequently die of this ailment, nothing is too much trouble if it insures success. We must not forget that the gastrointestinal tract is the most delicately balanced system of the entire living economy and is the only system that can be materially disturbed by sensations received through the optic, olfactory or auditory nerves.

To safeguard against toxic symptoms and to insure the patient of a fair night's rest and sleep, I give first a colonic irrigation of warm distilled water and then administer thirty to forty grains of sodium bromide in sixteen ounces of distilled water or else introduce a rectal suppository containing fifteen or twenty drops of deodorized tincture of opium, using precaution not to have a habit formed.

Early the following morning I have the patient quietly swallow the weighted end of a modified duodenal tube, requiring him to spend sometime on the right side after the tube has reached the pylorus. In about thirty or forty minutes the tube will be one or two feet in the jejunum. My modification of the original duodenal tube is its great increase in length, the end of which tube has long, fenestrated openings in it to prevent choking as the food escapes.

The fact that the end of this tube is two or three feet below the stomach, I have found to be of great value in preventing the tube from being forced back into the stomach and also the food from regurgitating should reversed peristalsis occur. Another great advantage in depositing this nourishment considerably down in the small bowel is that the stomach is given prolonged and continued rest, the presence of the tube usually not giving any sensation whatever.

If the patient tolerates the tube well, I leave it in situ all day; on the other hand, if it annoys the patient I remove it for about four hours around the middle of the day. The nurse can operate the feedings from behind a screen or even take the tube out of the window and connect it there.

The extent to which I carry out artificial digestion before introducing the various

foods depends entirely upon the analysis which I have previously been able to make upon the gastric contents. If all enzymes are absent, as they usually are in neurotic cases, I subject the liquid nourishment, such as purees, animal broth, toasted or untoasted cereal gruels, to thirty minutes' digestion on a hot-water bath, or other device, at about 37 degrees centigrade, using diluted hydrochloric acid, malt extract and pepsin.

If these feedings are given about every two or three hours regularly, the patient soon regains sufficient strength to have this process discontinued and begin gastric feeding by mouth, at which time normal hunger and appetite return.

THE USE AND ABUSE OF BIOLOGICS.*

By B. L. Arms, M. D.,
Director Division of Diagnostic Laboratories.

The State Board of Health has for some time furnished several biologic products for the use of the citizens, but even now there are many who do not understand just what is furnished. I must also confess that occasionally we find some who do not seem to understand that there are times when the use is not indicated; hence it was thought that a discussion might be of value, and I trust there will be a full and free discussion of the subject.

Antirabic treatments are ordered by wire on request to the executive office at Jacksonville, the treatments going direct from the biologic house to the physician who is to give the inoculations. When the patient is able to pay for this there is a charge of $20.00, but when both the patient and physician certify that the patient, or the one on whom the patient is dependent, is unable to pay, the treatment is furnished by the State Board of Health.

In regard to those cases that require treatment I regret to say that sometimes advice to take treatment is apparently given when such is not indicated.

This is borne out by the following correspondence that followed a negative report of the examination of a dog's head.

"State Board of Health.
"Jacksonville, Fla.

"Dear Sirs — Please send to me by mail the treatment for rabies. The child is eight years old."

Our reply follows:

"Dear Doctor—Your letter of the 12th to the State Board of Health has been given to me for reply.

"As the report of the examination was negative, we would ask a little more in detail in regard to the case before ordering treatment. In fact, not even a notice of the shipment of the dog ever reached us, and unless there is some reason for the treatment we would not advise it.

"Every dog should be accompanied with a statement as to symptoms of the dog, duration of symptoms, if the dog has bitten any one, and the location and severity of the bite. Kindly let us know all that you possibly can in regard to the dog.

"* * * We do not order treatment in a case of this kind until we have more definite history."

The following reply was received:

"The dog in question just broke the skin on the boy and the dog showed no signs of rabies."

In this instance, of course, there was no need for treatment, but it would have been given but for the request for information.

You can help many times by insisting that when possible an animal that has bitten an individual be confined and watched, for the best negative diagnosis is obtained in that way, and on the other hand if the animal is a rabid one, he will die within a few days and the microscopic diagnosis is then obtainable and, except in the case of severe face bites, there is no danger in the delay, while on the other hand this class of bites with any history

*Read before the Forty-sixth Annual Meeting of The Florida Medical Association, at Miami, May 20-22, 1919.

of rabies should be treated at once no matter what the miroscopic finding is.

Some months ago there was brought to the central laboratory the head of a dog that had been dead for several days, nor had it been iced. This dog had bitten a boy quite severely and the man who brought the head stated that he had been told by his physician that a diagnosis could be made even if the dog had been dead for two weeks. As soon as the head was brought into the laboratory the sense of smell was sufficient to tell us that no microscopic examination could be made, and this was confirmed when the skull cap was removed as there was only a small amount of pasty material in the cranial cavity.

In cases when no examination can be made complete reliance must be placed on the clinical history of the dog, and if it is, suggestive treatment should be advised where the bite has broken the skin.

The following biologics are free to all:

Diphtheria antitoxin, stocked not only at the laboratories but also at drug stores centrally located throughout the state. The main distributing point is the laboratory at Jacksonville and it will help you and us, too, if each of you will see that your antitoxin station has a fresh supply on hand. This is put out in 5,000 and 10,000 unit packages only and the State Board advises that cultures be taken from all contacts and on appearance of symptoms in one of these contacts that a therapeutic dose be given, but strongly advises against the use of immunizing doses of diphtheria antitoxin. There are two good reasons for this: (1) the Schick test has shown that a very large percentage of individuals are immune to diphtheria; (2) an immunizing dose of antitoxin often makes an individual capable of carrying the infection to others, he himself being immune but harboring the organism.

Tetanus antitoxin, stocked only at the laboratories. This is in two sizes — 1,500 units for prophylactic use and 5,000 units for therapeutic use.

Antimeningococcus serum; this can be obtained from the laboratory at Jacksonville and any request by wire or letter is filled at once. The serum is in 30 c.c. cylinders ready for administration.

Vaccine virus, stocked at the laboratories, although large quantities should be obtained from Jacksonville which is the distributing point for all the biological products.

Antityphoid treatments, obtainable at all the laboratories and in small amounts at the antitoxin stations. On account of the varying demand it is not feasible to keep full stocks at the antitoxin stations, but any request to the laboratory at Jacksonville will receive prompt attention.

The greater the number of prophylactic inoculations against typhoid you give in your community, the greater the amount of good you have done to that community, for the presence of typhoid is surely not an inducement for strangers to come and spend weeks or months in any locality. Freedom from typhoid is probably one of the greatest assets any city or town can offer as an attraction for prospective newcomers, whether they are to spend a short time or to become permanent residents. With a typhoid death rate much higher in this state than in the United States Registration area, we must do everything possible to lower it, and this can be done if all of us will pull together and immunize the greatest possible number of the people in the state.

A CORRECTION.

Through an error the names of the following charter members of The Florida Railway Surgeons' Association and The Florida East Coast Railway Surgeons' Association were not included in the list of charter members of these Associations published in the June issue of THE JOURNAL:

Doctor W. H. Adams, Jacksonville.
Doctor W. S. Grambling, Miami.
Doctor J. A. Stanford, Fort Lauderdale.

ROENTGEN DIAGNOSIS IN ITS BROADER APPLICATION.*

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Roentgen diagnosis in its broader application is of interest to the medical profession, not only in its relation to the patient, but in the greater accuracy of diagnosis. I shall discuss somewhat briefly a few prominent features of the work that have been impressed forcibly upon me in the last few years.

The range or scope of the examination to be made by the roentgenologist should not be limited. He is intimately concerned with accurate diagnosis, and is constantly meeting with the remote cause of disease, and also the concurrent cause of disease. One must not only consider the most prominent cause of the patient's distress but also the remote causes. For instance in the abdomen, pain or distress may arise from another point in the abdomen other than at the seat of location of the distress. At times epigastric distress may be due to tuberculosis of the lung with absolutely no lesion in the gastro-intestinal tract. In the field of abdominal distress one has to consider tuberculosis of the lung, chronic infection of the roots of the teeth, gall-bladder disease, lesions in the stomach and duodenum, the appendix, urinary calculus rarely, colitis, diverticulitis of the colon and still many other lesions.

In the examination of disease of bones and joints the roentgenologist is as much or more interested in finding the primary focus of infection, whether it be the teeth, sinuses, chest or gastrointestinal tract.

Many patients coming to me are in a sense making their last attempt to secure health. Their history may indicate an examination of the teeth, sinuses, chest, gall bladder and urinary tract and intestinal tract; and unless all these fields be covered we may miss the cause or presence of concurrent causes of their illness.

In injuries to the wrist one has a most fertile field for a Roentgen examination. Many sprains are fractures of the radius or carpal bones with little or no displacement. Several conditions I recall that are usually mistaken one for the other. The first is a fracture of one of the carpal bones which is most always considered a fracture of the head of the radius at the wrist. The carpal bones are so complexly articulated with one another that it will require a set of stereoscopic plates for a diagnosis. With a set of stereoscopic plates one gets a prospective and information as to position and possibility of damage that can be secured in no other way. Most all of the fractures of the scaphoid and dislocations of the semilunar in wrist injuries that I have seen were either unrecognized or mistaken for fractures of the radius. A fracture of the pelvis is most always considered a fracture of the femur at or near the joint, as the patient's chief disability is produced on movement of thigh.

Among lesions with remote causes, I saw recently an elderly woman with sciatica of a year's duration due to a ureteral stricture close to the bladder, and a ureteral calculus a few inches higher up. Another interesting and common injury seen recently which had been overlooked, but partly the patient's fault, was the following: A man was kicked by a Ford, and had the usual disability with a swollen wrist, which was put up in a splint, and called a sprain. At the end of six weeks he came to me with inability to move his wrist properly and some bulging seen on the palmar aspect of the wrist. An examination showed a complete dislocation of the semilunar bone to the palmar side of the wrist. Swelling primarily undoubtedly obscured the displaced bone. This patient, as many others that I have seen, impresses me with the fact that a Roentgen examination should be made of all wrist injuries, at least after the dressing has been applied.

In the field of chest diagnosis a pneumonia can be followed or a pleural effusion, and valuable diagnostic information can be

*Read before the Forty-sixth Annual Meeting of The Florida Medical Association, at Miami, May 20-22, 1919.

secured. Of course, this means that the patient must be confined in a hospital or the examiner have an adequate type of portable apparatus as can be secured today.

I have not attempted to discuss at length or minutely the value of the Roentgen examination, but rather have aimed to offer for your consideration some of its values, and to suggest a broader application of its use.

ATYPICAL SYPHILODERMS.*

J. L. KIRBY-SMITH, M. D.,
Jacksonville, Fla.

On selecting a title for a paper on cutaneous syphilis, atypical is the most expressive word at hand, literally meaning unusual, and truly syphilis is an unusual subject. The disease continually brings forth new features both in the field of diagnosis and treatment. At the present day, the subject of syphilis is evolving itself into a separate branch of medicine. It is being divorced from the genito-urinary and dermatalogical specialties. Some of our universities have established chairs in their colleges in which the subject of teaching syphilis is a separate department. The past few decades, research workers by their untiring efforts have brought the subject of syphilis from a thing of darkness and doubt to a subject as well defined in etiology, diagnosis and treatment as exists in the important diseases, such as typhoid fever and malaria.

All of you present will agree that an understanding and familiarity with the cutaneous symptoms of syphilis is a prime essential to a prompt recognition of the disease. No less an authority of medicine than Dr. Wm. Osler has stated "that an understanding of syphilis is necessary to diagnose diseases." The classical symptoms of syphilis require no special remarks, I mean the well-developed secondaries, eruptive and concomitant symptoms all present. Unfortunately for the patient and the diagnostician, the onset or course of the disease is not always uniform. Without a doubt, syphilitic manifestations are more protean than any disease we have to deal with. The features of most of the common and some rare dermatoses are at times imitated. In a paper of this scope the writer will not infer any originality in the points of attention, but will remind you of some of the atypical or unusual types of cutaneous syphilitis, and trust your interest in the subject will be stimulated. A knowledge of the common skin lesions is essential to diagnose a syphiloderm in the absence of concomitant symptoms, especially is this true of the rare, unusual types that often appear. At this point it may be well to mention the vagaries of the Wassermann. How often we are mislead by a too literal interpretation of the serological fraction.

Always bear in mind, the Wassermann is invaluable, but you must not depend entirely on this for confirming your tentative diagnosis. Before closing this paper a few points will be emphasized in the using of the Wassermann finding. The primary or chancre stage of syphilis presents few points that are atypical, especially is this true of the genital lesion. The normal, non-irritated, non-infected erosion is seldom seen and is always promptly recognized by its hard, button-like infiltration. The other type, the usual chancre, is often misleading. To diagnose this initial lesion promptly, one must resort to the microscope. Your attention is called to two very important considerations t hat have recently been demonstrated in the connection of initial lesions of syphilis—I could say genital sores. First, a recent report of a series of 200 consecutive cases occurring in one of our military cantonment dispensaries. By thorough microscopical examinations, 85 per cent of these genital lesions were found syphilitic. This shows the great preponderance of luetic over chancroidal lesions. Bear this in mind, gentlemen, that the genital sore is usually syphilitic, even though atypical in appearance. The second point—the absolute

*Read before the Forty-sixth Annual Meeting of The Florida Medical Association, at Miami, May 20-22, 1919.

necessity of early and prompt intensive arsphenamine treatment in a venereal sore. When in doubt, don't wait for secondaries; begin your measures at once. This is your one opportunity of completely checking the infection. To wait is to develop a disease that years of treatment are necessary to eradicate.

Extragenital chancres occur with frequency not generally appreciated by the profession. Especially is this true of the tonsillar and lip variety. To these infections you can attribute the origin of your syphilitics and who are without the history if an initial lesion or venereal exposure. Variously given percentages by well-known syphilologists place extragenital chancres as occurring in 8 to 15 per cent of cases—hence the importance of this phase of the subject. Always be on your guard in considering an ulcer or sore on the lip or tonsil. They are rarely typical of the picture you may have in your mind of a chancre.

The secondary or eruptive stage of syphilis is filled with usual and irregular phenomena. The classical roseola or macular eruption is rarely appreciated by the patient and is often overlooked or confused with the roseola of the exanthemata or toxic eruptions. Especially is this true with the patient having a small hardly noticed lesion on the penis two or three months previous. Sometime ago the writer had the opportunity of seeing a syphilitic who had been in a local hospital with a tentative diagnosis of typhoid fever. Some catarrhal symptoms, very slight roseola, no definite history of a chancre, Wassermann test reported anticomplementary, Widal negative, temperature curve not unlike typhoid. This patient consulted me for the loss of hair some weeks after leaving the hospital. Instead of the usual febrile alopecia the characteristic moth-eaten alopecia was present; further examination showed mucus patches in throat, tongue and buccal cavity, and a 4-plus Wassermann verified the clinical diagnosis of lues.

After the initial rash of syphilis, the characteristics of the eruption may vary from the simple macular to a general papulo-pustular eruption. In most cases you can by careful search uncover positive clinical symptoms to clear up the doubtfulness of your diagnosis. The papulo-pustular syphiloderm is oftentimes confused with variola, especially in the face of an epidemic of the latter. The small papular or follicular syphiloderm of slight distribution is sometimes mistaken for acne, particularly so the so-called iodide acne (dermatitis medicomentosus). Another atypical feature of this and other types is the symptom of itchiness which at times is as intense as an eczema. In the negro it is more marked, doubtless due to lack of cleanliness. Same could apply to any race. The late secondary syphiloderms show more atypical forms than any phase of syphilis. It is here that you may have a few lesions scattered or just one isolated group and no concomitant symptoms of the disease apparent. True, you may discover real evidence by careful examination of the skin and mucus membrane for characteristic scars of former lesions which are frequently to be found. The face, especially the nose, is the site for the late secondary lesions, either of the papular or the papulo-tubercular syphiloderm or the ulcerative papulo-tubercular lesion.

The occurrence of renalotic and scaly patches in the palms of the hands or soles of the feet in the majority of instances are late secondary syphilitic lesions. These hard and scaly patches are suggestive of a squamous eczema or psoriasis. Often you can not find any accompanying evidence of syphilis. The Wassermann will clear up the situation and salvarsan quickly relieve the patient of a very chronic and stubborn skin affection. The palmar syphiloderms are not an uncommon clinical type. The writer is of the opinion that women develop this type oftener than men. The distinguishing features of the palmar syphiloderms is the tendency to a papulo-serpiginous, outline of the border of the patches a dark-brown stain, appearance along this part thick and scaly, some scars of

ulceration. True, the palmar syphiloderms have several types. In the present instance the writer was referring to the squamous syphiloderm late in appearing.

The circinate or serpiginous or papulosquamous syphiloderm has an unusual predilection for the face of the negro. Of this type the writer has seen a number of cases in negresses, one or more groups appearing on the face. At first sight a ring-worm infection is called to mind; these isolated lesions existing for months and years without discomfort and no other active symptom of syphilis apparent. Generally though the circinate or serpiginous arrangement of the papular eruption is not confined to the face but distributed to most parts of the body. This type of cutaneous syphilis is often confused with the circinate arrangement of periotic lesions, Pitzniasis rosea, macular leprosy, trichophytosis or seporrhaic eczema, but by careful examination and process of elimination the symptoms of each of these conditions can be excluded, and further resorting to the Wassermann to substantiate the diagnosis. At this point of closing, a few words in regard to the Wassermann. Please understand me. These statements are the result of my own experience of eleven years with the serological test, and due apologies to the laboratory workers.

First: The Wassermann test in a well-developed syphilis will be of no value as to indication of prolonging or continuing treatment. In other words, the serological test is for purposes of diagnosis and not any index as to the thoroughness of treatment. It is the writer's opinion that the syphilitic antibody is not destroyable and as such is comparable to that of the immunity bodies that develop in variola. For instance, vigorous and intensive treatment of an acute syphilitic with arsphenamine and mercury temporarily produces a negative Wassermann. After an interval the serum will report positive. The neurologist will tell you this is due to reinfection from the spinal fluid, but they only suggest more intensive treatment. Anyway a later test will still show a positive Wassermann. As a rule I do not consider it possible to even get a permanent negative Wassermann, no matter how long or intense the treatment. My indication for suspending treatment are the stage of disease in which treatment was begun, the amount of treatment, and the physical condition of the patient.

The second point in regard to the Wassermann: Do not take the negative report as a final consideration in a doubtful case. Submit another specimen. The laboratory man can explain to some extent why a blood one day is negative and the following week 4-plus positive. Anyway it's the positive report that counts, and as a diagnostic help the Wassermann test is invaluable.

PROPAGANDA FOR REFORM.

ARSENOVEN S. S. AND SOLUTION OF ARSENIC AND MERCURY NOT ACCEPTED. — The Council on Pharmacy and Chemistry reports that Arsenoven S. S., sold by the S. S. Products Co., Philadelphia, and Solution of Arsenic and Mercury (formerly called Arseno-Meth-Hyd) of the New York Intravenous Laboratory, New York, are inadmissible to New and Nonofficial Remedies because unwarranted therapeutic claims are made for them and because the names are not descriptive of the composition of these preparations. Arsenoven S. S. is claimed to contain dimethylarsenin 15.4 grains, mercury biniodid 1-10 grain, sodium iodid ½ grain. Dimethylarsenin is asserted to be similar to sodium cacodylate, but with a more pronounced therapeutic action. Solution of Arsenic and Mercury comes in three dosages, 2 gm., 1.5 gm., and 0.7 gm., respectively. The 2 gm. form is claimed to contain 2 gm. (31 grains) of sodium dimethylarsenate (cacodylate), U. S. P., and mercury iodid 5 mg. (1-12 grain) in 5 c.c. of solution. Both preparations are advised for the treatment of syphilis, intravenously. The report of the Council reminds physicians that cacodylates have been found inefficient as spirocheticides

and warns against the abuses—often dangerous—to which patients are frequently subjected when "intravenous therapy" is employed. (*Jour. A. M. A.*, Aug. 2, 1919, p. 353.)

HORMOTONE AND HORMOTONE WITHOUT POST-PITUITARY. — The Council on Pharmacy and Chemistry reports that Hormotone of the G. W. Carnrick Company is advertised as "A pluriglandular tonic for asthenic conditions." The same firm also advertises Hormotone without Post-Pituitary for use "in neurasthenic conditions associated with high blood pressure." These preparations are sold in the form of tablets for oral administration. Each tablet of Hormotone is said to contain 1-10 grain desiccated thyroid and 1-20 grain of entire pituitary, together with the hormones of the ovary and testes — the amounts and the form in which the latter are supposed to be present are not given. From this it is seen that the only definite information given the medical profession regarding the composition of Hormotone is that it is a weak thyroid and a still weaker pituitary preparation. Hormotone without Post-Pituitary is said to contain in each tablet 1-10 grain desiccated thyroid, and to "present" "hormone-bearing extracts of thyroid, anterior pituitary, ovary, and testes." The Council declared these preparations inadmissible to New and Nonofficial Remedies, because: (1) Their composition is semisecret. (2) The therapeutic claims are unwarranted. (3) They are sold under names not descriptive of their composition, but suggestive of their indiscriminate use as "tonics." (4) In the light of our present knowledge, the routine administration of pluriglandular mixtures is irrational. (*Jour. A. M. A.*, Aug. 16, 1919, p. 549.)

BROMIDE AND ACETANILID COMPOUND.— The period of acceptance having expired for Granular Effervescent Bromide and Acetanilid Compound-Mulford, the Council on Pharmacy and Chemistry directed its omission from New and Nonofficial Remedies because an examination of the available evidence demonstrated that mixtures of this kind are inimical to rational medicine and the public. The use of mixtures of bromide and acetanilid in fixed proportions is irrational and prone to induce their indiscriminate use by the public—and this despite the perfectly frank declaration of the composition of this mixture by the manufacturer. (*Rep. Coun. Pharm. Chem.*, 1918, p. 58.)

CINCHOPHEN: FORMERLY ATOPHAN. — The Chemical Foundation, Inc., which has purchased some 4,500 German-owned patents, many of them for synthetic drugs, proposes to continue the wise policy of the Federal Trade Commission by requiring that those who receive licenses for the use of patents for synthetic drugs must use a common designation for each drug selected by the foundation. Cinchophen has been selected as the designation for the substance introduced as atophan (also described in the U. S. Pharmacopœia under "phenylcinchoninic acid"). In consideration of this action on the part of the Chemical Foundation and also because physicians found it difficult to use the pharmacopœial name phenylcinchoninic acid, the Council on Pharmacy and Chemistry has recognized the contracted term cinchophen as the name for the drug introduced as atophan. (*Jour. A. M. A.*, Aug. 9, 1919, p. 427.)

S. S. S.—The state of Louisiana has a law prohibiting the sale of venereal disease remedies, except on the written prescription of a licensed physician. In May of this year, the Bureau of Venereal Diseases of the Louisiana State Board of Health notified the druggists of Louisiana that the sale of "S. S. S." ("Swift's Syphilitic Specific" or "Swift's Sure Specific") would meet with the same law enforcement measures as were being waged against any venereal disease nostrum. The result of this notice was a letter sent to various drug stores of Louisiana by the sales manager of the Swift Specific Company declaring that "S. S. S." is not recommended or advertised as a venereal medicine. A few years ago, "S. S. S." was boldly heralded in newspaper advertisements as a "cure" for syphilis. (*Jour. A. M. A.*, Aug. 30, 1919, p. 707.)

The Journal of The Florida Medical Association

Owned and published by the Florida Medical Association.

Acceptance for mailing at special rate of postage provided for in Section 1103, Act of Congress of October 3, 1917; authorized October 16, 1918.

Published monthly at St. Augustine and Jacksonville. Price $1.50 per year; 15 cents per single number.

Contributions for publication in this journal, whether scientific papers or reports of County Secretaries, should be typewritten.

Address Journal of the Florida Medical Association, St. Augustine, Florida, or 335 St. James Building, Jacksonville, Fla.

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Next Place of Meeting — DAYTONA — May, 1920

"ACCEPTED BY THE COUNCIL ON PHARMACY AND CHEMISTRY."

The Council on Pharmacy and Chemistry of the American Medical Association is a department of our national organization that has not received the plaudits and encomiums of a wildly joyous medical profession nor the grateful praises of the enthusiastic manufacturer of pharmaceuticals. The council seems indeed to be the unloved child of the entire family of subsidiary bodies of the association. Perhaps the reason for this may be found in the character of its duties for the council must expose fraud, sometimes in high places, and protect the physician from being duped by avaricious persons and by persons who are themselves sometimes the victims of their own credulity. It thus happens that the sale of some proprietary article previously held in high esteem by the practitioner proves valueless, perhaps even fraudulent. The practitioner, however, may have credited much of his success in treating certain conditions to that preparation and the maker has had success in accumulating dollars from its sale and both parties emit a loud and vicious roar against the council, because they both lose money. Nobody wants to be "protected" against making money—make it honestly if possible, but make it—but this black sheep among the Councils of the American Medical Association insists on their making their money honestly!

Despite many obstacles thrown into its path, the Council on Pharmacy and Chemistry has serenely pursued its allotted tasks, corrected its mistakes, improved its methods, and today stands as the only medium to which the honest physician may turn for information—not misinformation—regarding proprietary articles. During the war the council and the chemical laboratory were in close cooperation with the Surgeon-General's Office, testing and investigating every article offered to the government for the treatment of the sick soldiers. The variety and the number of fakish and fraudulent stuff offered to the Surgeon-General was a pitiable

exhibit of the mental gymnastics of some people. Just now the council and the laboratory have a new and important field before them, *i. e.*, to protect the physicians against worthless and useless serums, vaccines and synthetics. It will be the council's unpleasant duty to expose the fraudulent and useless among these articles and stamp truth on those found worthy.

We seem to have wandered from the topic in our caption but not so in reality because the burden of our thought is to lend our influence to the spread of the motto of the Advertising Clubs of the World, namely, "Truth in Advertising." It is our purpose to stimulate a larger degree of enthusiasm for the work of the Council on Pharmacy and Chemistry and the Chemical Laboratory, a more generous flow of inquiries concerning articles unfamiliar to the physician, and particularly to urge that the words "accepted by the Council on Pharmacy and Chemistry of the American Medical Association" be printed on the label and on all advertising circulars of proprietary articles that have been admitted to New and Nonofficial Remedies. Then, when pamphlets and circulars are received by physicians they will read the statements of manufacturers with sympathetic understanding and with full confidence in the verity of the declarations. The importance of creating just that sort of receptivity in the mind of the prospective buyer is so well known to the astute publicity expert that it is needless for us to dwell on its advantages. Every proprietary article advertised in our *Journal*, in *The Journal of the American Medical Association*, and in the other state association journals, as well as in several well-edited privately owned journals, does in effect say to the reader that the articles so advertised are accepted by the council because only proprietary articles so accepted are accepted by us. The fact is further acknowledged when these firms are permitted to exhibit their goods at our annual sessions, for again the rule is enforced that only proprietary articles which have been approved by the council may be placed on display.

Why not complete the circle of ideas — it would not be a "vicious circle"— by printing on labels, in advertisements and circulars, the words: "Accepted by the Council on Pharmacy and Chemistry"?—*The Journal of the Missouri State Medical Association.*

NUTRITION AND SEX EXPRESSION.

The world-wide campaigns for the control of venereal disease have brought the social relations of individuals and their sex expression into a peculiar prominence. Experience has shown the necessity of a changed attitude toward the problems of the sexual life. A few years ago no group of persons outside of the medical profession treated the subject in a frank manner; but today the champions of so-called social prophylaxis are ready to adopt a straightforward view in relation to the sexual instincts and to plan their campaigns for betterment with due consideration to physiologic and environmental factors as well as to purely moral or ethical tenets. A recent writer[1] has remarked that the physical, the mental and the moral being is the result of heredity, environment and education. Science, he adds, does not take cognizance of sentiment, for that is the product of culture, and they who permit themselves to be governed by a sentimentality that ignores or conflicts with the established inexorable laws of nature must inevitably meet disaster.

A sane hygiene of sex must strive to learn what these "inexorable laws" of nature are. It is generally recognized that sexual emotions can be awakened or intensified by a variety of stimuli which affect the senses. The imagination undoubtedly plays a conspicuous part in many instances; nevertheless, aside from the more purely mental processes the sex expression finds its genesis in no small measure in the contributions of the special senses thereto. Sight and sound and touch enter into the peculiar complex in which physiologic and psychologic factors are mingled to give rise to the unique manifestations of sexual emotion.

Little is known and less has been taught regarding the purely physiologic background of these manifestations. It is understood, or at least assumed in a general way, that disease of the body as a whole may decrease or even abolish the sex expressions; thus, diabetes and extreme obesity are included among causes of sexual impotence. It has been very difficult, however, to secure definite information regarding possible relationships between the emotions of sex and special physical or metabolic functions of the organism. The topic is repulsive to those competent to furnish the facts; and even when they might be secured, introspection and suggestion combine to make them of questionable value for a strictly scientific analysis. An exceptional instance for securing reliable information seems to have been afforded by the investigations of the Boston Nutrition Laboratory of the Carnegie Institution of Washington on the effect of a prolonged restricted diet on human vitality and efficiency.[2]

Editorial reference has already been made in *The Journal* to the outcome of these human experiments. Briefly, the basal metabolism of the students living at decidedly reduced weight level brought about by a diet representing from two thirds to one half of their supposed calorific requirements was about 18 per cent lower per kilogram of body weight than prior to reduction. The systolic and diastolic blood pressures were lowered to about 90 and 65 mm., respectively. The pulse rate showed a marked drop. For example, five of the subjects showed many pulse rates 35 beats or below, and one man gave seven counts at 29 beats per minute. Body temperature, measured rectally, was normal, but the men complained of feeling the cold and wore more clothing. Neuromuscular coordinations presented some decrement; not enough, however, to interfere seriously with the duties of everyday life. There was no falling off in the quality or amount of the scholastic work. Strength tests indicated some decrease, but the normal amount of common physical activity appears to have been maintained. The men were not apparently lacking in vitality, nor were they inefficient. When engaged in vigorous athletics with their fellows, a stranger could not have picked them out.

Information cautiously acquired from the twenty-four young men who may be assumed, because of their training at the International Y. M. C. A. College at Springfield, Mass., to have a sound and wholesome attitude regarding these matters, reveals the circumstance that associated with the physical condition resulting from the low diet there was a diminution in sex activity.[3] It is needless to reiterate here the correlated opinions on which this conclusion was based. Miles[3] has called attention to the fact that, in these undernourished students, decreased sex expression accompanied a diminished rate of basal metabolism; and he ventures to remind us that the sex instinct is commonly stronger in men than in women, who have a lower basal level of metabolism. It is not on this ground illogical, Miles writes, that a lowered metabolism in men might reduce the manifestations of the sex instinct. Nature may require a high metabolic level for purposes of race propagation.

Miles' conclusion from his most unusual study has a direct interest for medical practice:

"Any dietetic régime which, even though it affects the external appearance and performance of an individual but little, definitely lessens the expression of the sex instinct, causing one sex to take but little interest in the other, would seem to be disadvantageous to the species if indefinitely prolonged and if the instinct made no adjustment thereto. Any general conclusions regarding a lowered nutritional level produced by prolonged reduction in diet may not disregard the effect on the sex instinct or its manifestations. On the other hand, the results clearly indicate a method of treatment for achieving restraint of sexual tendencies in pathologic cases of sexual dissipation."—*Jour. A. M. A.*

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1. Malchow, C. W.: The Sexual Life, St. Louis, C. V. Mosby Company, 1917.
2. Benedict, Miles, Roth and Smith: Human Vital-

ity and Efficiency Under Prolonged Restricted Diet, Pub. 280, Carnegie Institution of Washington, 1918; Benedict, Miles, Roth and Smith: The Effects of a Prolonged Reduced Diet on Twenty-Five College Men, Proc. Nat. Acad. Sc. 4: 149, 1918.

3. Miles, W. R.: The Sex Expression of Men Living on a Lowered Nutritional Level, J. Nerv. & Ment. Dis. 49: 208 (March) 1919.

THE AMERICAN PUBLIC HEALTH ASSOCIATION TO MEET IN NEW ORLEANS.

The next annual meeting of the American Public Health Association is to be held at New Orleans, Louisiana, October 27th to 30th, inclusive. The central themes of discussion will be Southern health problems, including malaria, typhoid fever, hookworm, soil pollution and the privy, etc.

The general belief among the health profession is that influenza will return next winter, and a full session will therefore be devoted to this subject for the purpose of developing methods of control.

A special effort has been made to arrange the program to meet the practical needs of health officials. Accordingly there will be discussion on such questions as the attitude of legislators towards public health, the obtaining of appropriations, cooperation from women's clubs, health organizations, etc., the organization of health centers, and so on.

The programs of the sections will, as usual, deal with public health administration, vital statistics, sanitary engineering, laboratory methods, industrial hygiene, sociology and food and drugs.

Two special programs will also be presented on various phases of child hygiene and personal hygiene.

Winter railroad rates to New Orleans will be in effect from all points after October 1st.

The program of the meetings will be published in the *American Journal of Public Health* appearing October 5th, or may at that time be had upon application to the Secretary, 169 Massachusetts Avenue, Boston, Mass.

FRAUDULENT "CURES" FOR VENEREAL DISEASES SEIZED.

By order of the Federal Courts more than 450 seizures have been made recently in different parts of the United States of so-called cures for venereal diseases. They were made on information furnished by officials of the United States Department of Agriculture through its Bureau of Chemistry. A campaign to end the false labeling of such preparations is being conducted by the officials charged with enforcing the Federal Food and Drugs Act.

The goods seized include a great variety of compounds. Some of the labels bear the claim of the manufacturer that the contents are sure cures for venereal diseases. Some even contain statements that cures will be effected within definite periods, varying from three days to a few weeks. In others indirect statements, suggestive names or deceptive devices are craftily used to make it appear that the use of the preparation will be followed by a cure of the disease.

In all the seizure actions the Government alleged the preparations to be falsely and fraudulently labeled, because the ingredients could not produce the results claimed on the labels.

The officials state that such preparations are sold largely because of plausible but false claims regarding their curative effect. Many sufferers with dangerous contagious venereal diseases are led to believe that cures will be effected by these preparations, and adequate treatment under competent medical supervision is neglected until permanent injury to health and even danger to life has resulted. Thus is created one of the greatest obstacles to the proper control and eradication by health officials of venereal diseases. In many instances had such sufferers secured competent advice, early and complete cures might have been effected.

Self-treatment with worthless concoctions causes not only continued suffering but sometimes permanent injury to the unfortunate victims and makes of them a menace to the

public health because of the extreme danger of others contracting the disease from them.

Action under the Federal Food and Drugs Act in reference to venereal-disease preparations coming under its jurisdiction and sold under proprietary names is limited by the terms of the act largely to the prevention of false or fraudulent labeling. The act does not prevent the sale of any mixture as medicine, however worthless it may be, if there is directly or indirectly no false or fraudulent labeling. The officials in charge of the enforcement of the act are of the opinion, however, that by causing the elimination of false labeling, upon which the sale of such preparations largely depends, the evils and dangers resulting from their indiscriminate use can be greatly checked, and substantial aid rendered to public health officials.

WANTED: ONE MILLION WORKERS.

Organization and Publicity!

These are the names of the two pillars which must support the arch in the Third Red Cross Roll Call for members and drive for $15,000,000 this fall.

In order that the roster of American humanitarianism may be thoroughly representative of this vast and rich nation, an organization that will extend along all the byways as well as the highways is absolutely essential. Organization, then, is the first big step.

It is roughly estimated that one million volunteer workers, who can give generously of their time, are needed for early mobilization and coaching for the intensive campaign which will take place during the period beginning November 2 and ending the evening of November 11, Armistice Day. The preliminaries necessary to the perfection of an organization of one million workers are being directed from National Headquarters, from which text posters are being sent to every postoffice, telegraph office and public library in the land.

In enrolling workers, service men are wanted in unlimited numbers. You'll find friends of the Red Cross among them and willing workers, too. Get the men in uniform into this roll call and drive, and your local campaign will *go* from the start. Men and women who can speak and write and serve in semi-executive capacities during the campaign should be on the job, primed for real American action, weeks ahead of the designated ten days.

And when this organization *is on the job*, the slogan of paramount importance is one word—Publicity.

So, with proper organization and publicity, this roll call and drive in behalf of peace-time preparedness for our Red Cross—for the countless benefits of home service for the families of soldiers, sailors and marines, a service that is to be extended in many instances to civilian families; public health nursing, epidemic prevention work, domestic disaster relief, and the completion of certain remaining obligations to destitute war-sufferers abroad—will be the great success which it is urgent it should be. — *Red Cross Bulletin.*

ROLL CALL OF AMERICANISM.

Dr. Livingston Farrand, Chairman of the Executive Committee of the American Red Cross, recently announced a nation-wide Red Cross campaign to open on November 3, and to close November 11, Armistice Day.

The primary object of the campaign is to enroll members for the year 1920, but there will be in addition, a general appeal for Fifteen Million Dollars, to enable the Red Cross to complete its war obligations at home and abroad, and there will be local appeals, where necessary, conducted by chapters to secure whatever money they may need to finance their local programs.

During the war there were two annual campaigns, the War Fund Drive in the late spring and a Christmas Roll Call for membership. The only campaign this year will be the one in November and in succeeding years there will be an annual Roll Call in which the Red Cross will seek the reaffirmed allegiance of the American people expressed in dollar memberships, the money so derived to be used for American purposes, and the

approval thus received to be regarded as a mandate to carry on future programs.

The first task of the Red Cross is, of course, to complete its obligations to American soldiers and sailors. The great organization plans, as its future policy, to concentrate its efforts upon peace problems at home, unless America should again be involved in war or confronted by great disasters creating special emergencies. The Red Cross programs are primarily within the field of Public Health and will aim particularly to cooperate with official activities, Federal, State or Local. The Red Cross will seek not to duplicate the work of established organizations, but will endeavor to supplement other agencies where they already exist or to stimulate and organize work where none such exists.

The great work which the American Red Cross did during the war has, however, left a continuing obligation, which can not be fulfilled for some months to come. In an amendment to the Army Bill, Congress prolonged the responsibility of the Red Cross abroad by authorizing the Secretary of War to transfer to the American Red Cross such medical and surgical supplies, and supplementary and dietary foodstuffs now in Europe, as should not be needed by the Army abroad or at home, to be used by the American Red Cross, "to relieve and supply the pressing needs of the countries involved in the late war."

Inventories of these supplies are now being made. To them will be added such materials as the American Red Cross has itself in Europe, and these will be distributed in those countries in which the American Red Cross is concluding its war relief program, and where, because of the ravages of war, famine and epidemic, the distress is most pronounced, as in the Balkans, Poland and other Eastern European countries.

To meet all these obligations and to administer this foreign relief the Red Cross must raise at this time a fund of Fifteen Million Dollars.

Doctor Farrand said that the Red Cross authorities realize that the astonishing generosity of the American people during the war and the present high cost of living at home might legitimately lead many to expect a release from further demands for assistance to other peoples, but that we must remember that our Allies were much harder hit by the war than were we and that we have incurred obligations to them which honor demands shall be discharged.

In naming the sum of Fifteen Million Dollars the Red Cross has tried to determine the smallest amount which will enable it to round out its work and make effective the appropriation of Army goods rather than to estimate the generosity of the American people.

It is believed that the end of these foreign obligations is in sight, and the Red Cross is turning its chief attention and energy to the development of a clearly defined home program, which already includes systematic preparedness for Disaster Relief, a widespread Nursing plan, continuing Home Service operations, First Aid instruction, and a Junior Red Cross program, all of which will depend for their success upon large and vigorous Chapters. For these reasons, the enrollment of members is the chief purpose of the November campaign. It is the primary ambition of the American Red Cross to be of service to Americans.—*Red Cross Bulletin.*

NEW AND NONOFFICIAL REMEDIES.

BARBITAL SODIUM-ABBOTT.—A brand of barbital sodium which complies with the New and Nonofficial Remedies standards. Barbital sodium is the soluble sodium salt of barbital (veronal). Barbital sodium was first introduced as veronal sodium and medinal. For a discussion of the actions, uses and dosage of barbital sodium see New and Nonofficial Remedies, 1919, p. 83. The Abbott Laboratories, Chicago.

OVARIAN SUBSTANCE-HOLLISTER-WILSON.—The entire fresh ovary (including the corpora lutea) of the hog, cleaned, freed

from fat, dried and powdered. It contains no diluent or preservative. For a discussion of the actions and uses of ovary preparations, see New and Nonofficial Remedies, 1919, p. 202. The dose is from 0.06 to 0.2 gm. (1 to 3 grains). The Hollister-Wilson Laboratories, Chicago.

DESICCATED CORPUS LUTEUM-HOLLISTER-WILSON. — The fresh substance from the corpora lutea of the hog, dried, freed from fat and powdered. It contains no diluent or preservative. For a discussion of ovary preparations, see New and Nonofficial Remedies, 1919, p. 202. The dose is from 0.03 to 0.12 gm. (½ to 2 grains). Hollister-Wilson Laboratories, Chicago.

GONOCOCCUS BACTERIN (SPECIAL BACTERIAL VACCINE NO. 9). — A gonococcus vaccine (see New and Nonofficial Remedies, 1919, p. 285), marketed in 10-c.c. vials, each cubic centimeter containing 1,000 million killed Gonococcus. Fred I. Lackenbach, San Francisco.

STAPH-ACNE BACTERIN (SPECIAL BACTERIAL VACCINE NO. 6).—A mixed bacterial vaccine (see New and Nonofficial Remedies, 1919, p. 296), marketed in 10-c.c. vials, each cubic centimeter containing 500 million killed Staphylococcus albus, 500 million killed Staphylococcus aureus, and 50 million killed Bacillus acne. Fred I. Lackenbach, San Francisco.

STAPHYLOCOCCUS BACTERIN (SPECIAL BACTERIAL VACCINE NO. 1). — A staphylococcus vaccine (see New and Nonofficial Remedies, 1919, p. 289), marketed in 10-c.c. vials, each cubic centimeter containing 2,000 million killed Staphylococcus albus, 2,000 million killed Staphylococcus aureus, and 1,000 million killed Staphylococcus citreus. Fred I. Lackenbach, San Francisco.

B. COLI BACTERIN (SPECIAL BACTERIAL VACCINE NO. 12).—A colon bacillus vaccine (see New and Nonofficial Remedies, 1919, p. 283), marketed in 10-c.c. vials, each centimeter containing 5,000 million killed Bacillus coli. Fred I. Lackenbach, San Francisco.

WHOOPING COUGH BACTERIN (SPECIAL BACTERIAL VACCINE NO. 14).—A pertussis bacillus vaccine (see New and Nonofficial Remedies, 1919, p. 287), marketed in 10-c.c. vials, each cubic centimeter containing 2,000 million killed B. Pertussis. Fred I. Lackenbach, San Francisco.

STREPTOCOCCUS BACTERIN (SPECIAL BACTERIAL VACCINE NO. 10).—A streptococcus vaccine (see New and Nonofficial Remedies, 1919, p. 291), marketed in 10-c.c. vials, each cubic centimeter containing 1,000 million killed Streptococcus. Fred I. Lackenbach, San Francisco.

TYPHOID BACTERIN (SPECIAL BACTERIAL VACCINE NO. 17).—A typhoid vaccine (see New and Nonofficial Remedies, 1919, p. 292), marketed in 10-c.c. vials, each cubic centimeter containing 1,000 million killed B. Typhosus. Fred I. Lackenbach, San Francisco.

DIPHTHERIA TOXIN-ANTITOXIN MIXTURE-LEDERLE.—A mixture consisting of five L+ doses of toxin and 6.25 units of antitoxin. Marketed in vials containing one dose. Three doses are packed in a carton. Schieffelin and Co., New York.

PUBLISHER'S NOTES.

NEGATIVE OR POSITIVE?

Is the gauze which you use on wounds of a negative or positive character? In other words, is the gauze merely negatively aseptic, meaning that it will not of itself infect the wound; or is it positively antiseptic, with the faculty of keeping out infection and of inhibiting infectious processes in the wound itself?

Given the choice of the two, surely the latter, the one which is actively antiseptic instead of passively aseptic, is to be preferred.

Such a dressing is Chlorazene Surgical Gauze, a new addition to the well-known Chlorazene family, supplied by The Abbott Laboratories, of Chicago, Ill., which is now introducing it as "the fighting dressing for wounds." We who are familiar with the

well-known action of Chlorazene can well believe that it marks another step forward in the modern dressing of wounds.

Chlorazene Surgical Gauze, we are assured by The Abbott Laboratories, contains more than 5 per cent of impregnated Chlorazene. This amount is guaranteed not only at the time of manufacture but also at the time of use. To support this they show that a strip of the gauze which assayed 6.44 of Chlorazene was kept under ordinary conditions for over six months and at the end of that time assayed 6.35—a loss of less than one-tenth of one per cent.

Chlorazene Surgical Gauze is now being marketed in one-yard and five-yard rolls. Its price compares favorably with other antiseptic gauzes on the market. Its greater effectiveness due to the greater potency of Chlorazene over the substances commonly used as antiseptics should be taken into consideration.

Physicians are invited to try this new surgical gauze at the expense of The Abbott Laboratories. A post card or any other form of request for a trial strip will be taken care of promptly. We suggest sending for yours today.

That Condition, Doctor, Is Not Uncommon

Notice today the number of growing girls and women whose ankles rotate inward and who walk with feet abducted which improper posture eventually causes pelvic disorders.

Prescribe proper foot-wear and

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which are especially designed to support the weakened structure, remove abnormal pressure and strain and restore normal functioning of muscular structures. These scientific appliances are now sold by leading shoe dealers and surgical instrument houses who have been instructed by our Educational Department how to properly fit them as prescribed by the physician.

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